APPLICATION FOR WELL CHILD CLINIC

Return to: Ravalli County Public Health Nursing Service, 205 Bedford, Suite L, Hamilton MT 59840

Head of Family: (Full Name) _____

Home Address: _____

Mailing Address (if different): _____

Home Phone: _____ Message Phone: _____ Cell Phone: _____

List all Household Members:

	Name	**Birthdate**	**Sex**
Father:			
Mother:			
Children:			

(Use back of page if more space needed)

1. Tell us about your children's health or medical problems. This may include allergies, serious illnesses, operations, and any health problems requiring a doctor's supervision and/or medications.

_____

_____

_____

2. Tell us about the health or medical problems of other family members.

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3. Which Ravalli County doctor do your children usually see? _____

   Date your children last had physical exams or Well Child Care? _____

4. Do you have health insurance? _____ If yes, does it pay for "Well Child" care? _____

   Do you have or have you applied for Medicaid (Welfare medical help)? _____

5. What is your current monthly gross income (before deductions)? _____

   What was your family's gross income income during the last 12 months? _____

   Do you receive WIC? _____

6. What is your occupation(s)? _____

   Where are you employed? _____

   Have you been unemployed or had large medical expenses in the past 12 months? _____

   If yes, please explain: _____

Other information:

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